# NEW CLIENT FORM

*Thank you for giving us the opportunity to care for your pet(s). So that we may become better acquainted, please complete the following:*

**CLIENT INFORMATION** **Date**_____

**Name** _____ **Spouse/Partner's Name** _____

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Phone** _____ Home/Cell**Spouse's/Partner's Phone**_____Home/Cell

**E-mail Address**_____**Best way to be reached**____Phone/Email_____

***PLEASE BE INFORMED THAT ONLY THE OWNER/S OR AUTHORIZED AGENTS LISTED ON THE ACCOUNT FOR THE PATIENT/S MAY REQUEST, CONSENT, AND AUTHORIZE TREATMENT ON PETS, UNLESS OTHERWISE WRITTEN CONSENT IS SUBMITTED TO LAKERIDGE ANIMAL HOSPITAL, LLC.**

***ALL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.**

**Please indicate choice of payment:** Cash Visa Master Card Debit Discover Care Credit

**How did you become aware of our clinic?** Drove By Facebook Website Previous Client
Personal Recommendation (Whom may we thank?)_____

**Patient Information**

**Patient Name:**_____**Date of Birth:**_____**Species:** Cat/Dog**Sex**: Male/Female Neutered/spayed
**Breed**_____**Color**_____**Microchip:** Yes/No**Microchip Number:**_____
**Last Vaccinated:**_____**Any Prior Vaccine Reaction:** yes/no **Type of Reaction**_____
**Previous Veterinary Office/Veterinarian:**_____
**May we contact them for medical records:** yes/no
**Current Medications/Special Diet**_____
**Current Heartworm/Flea Prevention**_____
**Current Problems/Concerns:**_____

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